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OF THE

AMERICAN COLLEGE of SURGEONS

VOL. IX OCTOBER, 1925 NO. 3

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40 EAST ERIE STREET :: :: CHICAGO

STORAGE

BULLETIN

OF THE

AMERICAN COLLEGE *of* SURGEONS

VOL. IX OCTOBER, 1925 NO. 3

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OUR DISTINGUISHED GUESTS

THE RIGHT HON. LORD DAWSON of Penn, G.C.V.O., K.C.M.G., C.B., M.D., of London, England, Physician in Ordinary to H. M. the King, has obtained special consent to attend the Philadelphia Clinical Congress of the American College of Surgeons. He is to deliver the Fellowship Address at the convocation of the College to be held on Friday evening, October 30, in the ball-room of the Bellevue-Stratford Hotel.

Lord Dawson is an eminent internist; he is Physician to the London Hospital; Consulting Physician to the King Edward VII Sanatorium at Midhurst, and the Royal National Hospital for Consumptives at Ventnor; Member of the Senate, University of London; President, Medical Society of London; Fellow, Royal Society of Medicine; late Medical Registrar, London Hospital; and Pathologist and Assistant Physician, Royal Hospital for Diseases of the Chest, City Road. Author of *Diabetes Mellitus*, *Diabetes Insipidus*, *Rheumatoid Arthritis*, *Allchin's Manual of Medicine, vol ii*, *Diseases of Lymphatic Vessels*, *Paratyphoid Fever* (with Whittington), *Jaundice of Infective Origin* (with W. E. Hume), *Colon and Colitis*, *Dyspepsia and Its Underlying Conditions*, and other articles and monographs on allied diseases.

Lady Dawson will accompany her distinguished husband on his trip to America.

SIR WILLIAM ARBUTHNOT LANE, BT., C.B., of London, England, who was one of the distinguished guests of the Clinical Congress in Chicago in November, 1913, and who was present at the opening meetings and First Convocation of the American College of Surgeons, is well known to American surgeons. He has accepted the invitation of the College to deliver the Sixth Doctor John B. Murphy Oration in Surgery, "A Tribute to Doctor Murphy," at the Presidential meeting of the forthcoming Clinical Congress on Monday evening, October 26, 1925. He is Surgeon to Guy's Hospital, Hospital for Children, and the French Hospital, all of London. Author of *Diseases of Joints, Hernia, etc.*, *Operative Treatment of Chronic Intestinal Stasis*, *Cleft Pa'ate and Hare Lip*, *Operative Treatment of Fractures* and many other books, articles, and monographs on surgical subjects.

Sir Arbuthnot will be accompanied by Lady Lane, and his son, Mr. William Lane.

PROFESSOR VITTORIO PUTTI, of Bologna, Italy, one of the outstanding orthopedic surgeons of the world, has accepted the invitation of the Clinical Congress to attend its sessions and to deliver an address at one of its meetings on a phase of orthopedic surgery in which he is much interested. He is Professor of Orthopedic Surgery in the University of Bologna, which has over three thousand students, each one of whom is required to attend a course in orthopedic surgery. For the past twelve years he has been Director of the "Instituto Ortopedico Rizzoli." This Institute, formerly a large Olivetian Monastery, was established by the generosity and foresight of Dr. Rizzoli, a general surgeon of Bologna, through whose bequest it was purchased, converted to its present use, and partially endowed. It is a modern orthopedic hospital, which accommodates usually about fifty free and one hundred and fifty contributing patients. Professor Putti devotes his entire time to the Institute, where he treats all of his patients.

The Institute has a two-fold purpose: it is a curative hospital and a center for the study and teaching of orthopedic science. It has three gymnasia; in the basement is a well-equipped laboratory for making all routine investigations and carrying out researches; the museum contains preparations of the ordinary kind, and in addition a large collection of plaster casts, and small scale models; complete case records are kept, and full use is made of photography as an aid to accurate recording, all of which is made available immediately for teaching purposes; drawings are also used in cases where necessary, and plaster casts are preserved in the museum. In the library are over eight thousand books of reference, and almost as many theses on orthopedic subjects. A journal

is published bimonthly in which appear the original papers of the Institute, and abstracts of leading articles in current orthopedic literature.

While Professor Putti is a very busy man, he is thoroughly conversant with details of the work in every department, where one can see the impress of his enthusiasm, his vigor, and his progressive and orderly mind. He is the senior surgeon, administrator, editor, consultant, author, university professor, and head of one of the largest orthopedic workshops in the world. (Abstracted from Brit. J. Surg., 1923, xi, 137–147.)

Dr. Victor Pauchet, of Paris, France, will be the guest of the Clinical Congress in Philadelphia, and has consented to read a paper at the Tuesday evening meeting on: "Experiences in the Surgical Treatment of Gastric, Duodenal, and Jejunal Ulcers." He is Professor of Clinical Surgery in the School of Medicine at Amiens, and Surgeon to the Hospitals; Surgeon to St. Michael's Hospital, Paris; Medical Chief of the Hospital of the Louvre; Chief Surgeon during the Great War to the Military Hospital of the Louvre. His work in stomach and abdominal surgery is specially noteworthy, and he has written many articles pertaining thereto.

William Blair Bell, B.S., M.D., M.R.C.S., of Liverpool, England, is a gynecologist of the first rank who has many acquaintances and friends in America, and upon whom the American Gynecological Society conferred an Honorary Fellowship in 1922. He is Gynecological and Obstetrical Surgeon to the Royal Infirmary, and Professor of Obstetrics and Gynecology in the University of Liverpool; Surgeon to the Maternity Hospital; Consulting Gynecological Surgeon to the Wallasey Cottage Hospital; he has received the Hunter Medal and Triennial Prize from the Royal College of Surgeons and also the Astley Cooper Prize; he is an Associate in King's College; President, North of England Obstetrical and Gynecological Society; a Fellow, and Vice President of the Section on Obstetrics and Gynecology, of the Royal Society of Medicine; Member of the Liverpool Medical Institute; late Examiner in Obstetrics and Gynecology, Consulting Board of England and the Universities of Durham and Belfast; Hunterian Professor, and Arris and Gale Lecturer to the Royal College of Surgeons; Author of *Disorders of Function; Principles of Gynecology; The Sex Complex; The Pituitary;* and articles on *Sexual Function of Woman, Normal and Pathological, Operation on Fallopian Tubes, etc.*

Philip Franklin, M.D., F.R.C.S., of London, England, an American by birth, is one of the leading nose and throat specialists of London. He is the Honorary Organizing Secretary of the American Hospital in London, for the use of American Medical Graduates studying in Europe, which was organized early in 1919; and during the recent sojourn in London of the Interstate Post-Graduate Assembly, as the London Chairman of the British Isles Committee, Mr. Franklin placed himself at the service of the visitors from the western hemisphere and improved every opportunity to aid them in making the most of their visit.

Mr. Franklin is Eye, Ear, Nose and Throat Surgeon to the East London Hospital, the Children's and Infants' Hospital, and the Royal Air Force Hospitals at Eaton and Bryanston; Laryngologist to the Margaret Street Hospital for Consumptives and the Fairlight Sanatorium, Hastings; Assistant Surgeon and Honorary Registrar, Metropolitan Ear, Nose, and Throat Hospital; Assistant, Aural Department, Middlesex Hospital; Fellow, Royal Society of Medicine and Honorary Secretary of the Otological and Laryngological Section; Member, Medical Society of London and the Harveian Society; Author of *The Middle Ear, The Internal Ear, Importance of Nose-Breathing in Infancy, Elements of Nasal and Aural Hygiene, Tonsils and Adenoids, Case of Lateral Proboscis, etc.*

Mr. Franklin will be accompanied on his trip to America by his wife and daughter.

POSTGRADUATE STUDY IN EUROPE

ERWIN R. SCHMIDT, B.A., M.D., F.A.C.S.
Junior Surgeon, Augustana Hospital, Chicago

POSTGRADUATE study in Europe is the ambition of every medical man who has the interest of his profession at heart. Before planning such a study it is best to take advantage of the courses and clinics which our own country offers. Many foreigners come to our shores to broaden their outlook and to obtain knowledge impossible to secure in their own land, but not before they have profited by visiting the clinics of their own and surrounding countries. No one country has a monopoly of the best in medicine. An exchange of views and ideas is always beneficial.

A trip abroad should not be made upon the spur of the moment, at least not for the man who is going for the first time. Unless careful plans are made there will be many disappointments. There is so much to be seen, such distances to be covered, new customs and manners of living to learn, that a great deal of time may be lost. It is imperative that one know the branches of medicine he wishes to study. Through the medical literature, through organizations such as the American College of Surgeons, through individuals who are familiar with the different clinics, and through correspondence, information may be obtained as to the clinics which afford the better opportunities for such study.

A knowledge of the languages is most convenient although the scientific terms are much the same. German may be used in the clinics of Germany, Norway, Sweden, Finland, Denmark, Holland, Switzerland, Austria, and Hungary. French is of great help in France, Belgium, Italy, and Spain. Many of the medical men of Europe are such linguists that a person speaking only English may be able to learn a great deal.

Letters of introduction will aid greatly in affording access to the different clinics. They are not always necessary. If a visit is paid the chief of the clinic, satisfactory arrangements can usually be made. There is much more formality in the European clinics than in those of our own country.

Most American medical men plan to make their study trips during the summer months. It is at this time that the heavy tourist travel is on between our own country and Europe, and consequently accommodations are more or less difficult to secure. From the latter part of June until the opening of the fall semester the chiefs of the European clinics are usually on vacation and a comparatively small amount of work is done during this time. In view of these facts, the most opportune time for a study trip abroad is during the fall or winter months.

If a definite amount of time, several months to a year, is to be spent at the clinic which offers the greatest advantages in the particular branch of medicine in question, one may, during this time, secure information as to what clinics should be visited to supplement this study. If time is limited, a listing of the clinics and a knowledge of what each has to offer, will help one to make a satisfactory clinical tour and as much time as is advantageous may be spent at each clinic.

All the larger clinics offer desirable courses, which may be arranged through the chief-of-staff. The courses are usually given by the older assistants. An intimate knowledge of the work of the clinic is gained in this way. Study should not be limited to medicine. There are many opportunities in other fields which should not be overlooked.

In Vienna the American Medical Association has a secretary, who is able to give any information regarding clinics and courses. In Paris a list of the University clinics may be obtained from the secretary of the Faculty of Medicine. The American Medical Association of Budapest has been organized and is functioning much as its sister society in Vienna. In the other cities there is no definite listing of clinics. In the smaller towns, where only one clinic is located, there will be no difficulty.

In this country the American College of Surgeons is furnishing information concerning the clinics of America. Each day a clinical bulletin is issued in New York and Chicago giving all the clinics for the day. At the present time the College is attempting a listing of the foreign clinics in order that anyone desiring this information may obtain it readily.

ESSENTIAL FEATURES FOR THE ORGANIZATION AND OPERATION OF A DEPARTMENT OF OPHTHALMOLOGY AND OTOLARYNGOLOGY IN A GENERAL HOSPITAL

RALPH A. FENTON, A.B., M.D., F.A.C.S.

Associate Professor, Department of Ophthalmology and Otolaryngology, Univ. of Oregon Medical School, Portland, Oregon

THE attitude of general hospital authorities toward the needs of otolaryngology and ophthalmology reminds one of the picturesque remarks made by an old-fashioned regular army medical colonel, whose hospital was moved from the Verdun area into occupied Germany. He grudgingly set aside two little dark inside rooms in an old barracks without running water or electric light, announcing that that was plenty good enough for any dashed blanked eye doctor! Unfortunately for his peace of mind, however, very few cases showed up for his spacious and well appointed general surgeries; and from fifty to sixty eye and ear-nose-throat cases per day began pouring in from neighboring divisional areas. No more gunshot wounds or gas cases, but a lot of eyestrain, tonsillitis, sinus and ear involvements; the war was over, and peace conditions had to be met. The colonel yielded to suggestions from headquarters, and adequate provision for the specialists was made.

So with civil hospitals, the needs of the general surgical and medical staff have often outweighed those of numerous special clinicians. Furthermore, so much special work is now being done by general men whose preparation in such lines is inadequate that the very simple needs of an eye and ear department are much misunderstood.

The essential features for the organization and operation of a department of Ophthalmology and Otolaryngology in a general hospital in my opinion are as follows:

Personnel

The eye or ear man should understand that he must come at once when sent for, not in two or three days. Findings in special sense organs change rapidly, and conclusions of great value may be missed by delay. Case histories are often valueless because such findings are inadequate.

Where a great deal of routine work is to be done it has been found desirable to divide the work into three-month services. Thus assistants, working under responsible teaching chiefs, have time off for vacation, travel, and study, and yet are on hand for six months of each year, following the cases they have examined through the hospital. At all times this material is being used for clinical instruction. Internes rotate in this service, being permitted to assist and do simple operations.

Records

The records may be simplified by providing a combination eye and ear-nose-throat blank on one side, and the standard operation form on the other side, thus cutting three sheets to one. Findings should be recorded and signed when observed, not left to a busy interne who is unfamiliar with special terminology. The gist of special findings should be set down in outline so that the specialist's conclusions will stand out for quick reference by others interested.

Clinical Laboratory

The clinical laboratory staff should be prepared to take coagulation tests in all throat cases. Sterile tubes or bottles should be on hand for specimens of pus or tissue, as also blood-agar and broth for culturing hemolytic organisms. Staining technic for the various conjunctival bacteria should be available, and a prompt report obtainable on either eye or throat smears, especially gonorrheal, pneumococcic, or Vincent's. Pathological examination of enucleated eyes, tonsils, and other tissues should be made.

Examining Rooms

Examining rooms should be provided if an outpatient department exists. These should include a well lighted eye treatment room with twenty-foot distance for vision test (this may be had by a mirror at ten feet and reverse type cards); a dark room used for retinoscopy, ophthalmoscopy, and transillumination, which should be well ventilated; and an ear-nose-throat treatment and examining room with frosted or daylight blue lamps, headrest chairs, stools, etc. Compressed air spraying and suction devices, Barany turning chair for labyrinth testing, tangent, screen, perimeter, phorometer, test lenses, and the like may be installed if detailed examination of ambulatory cases be desired. However, it is the practice of most specialists in these lines to use apparatus in their private offices for such detailed studies, though

the hospital ought to have as much available as space and finance allow.

Dark room facilities may be borrowed from the X-ray department, or be arranged for bed patients by high screens and dark blinds, or by a dark blanket tent. Use of electric-lighted appliances with battery handles is most desirable. The May-Wappler model ophthalmoscope is the smallest and simplest in its line. Transillumination is readily done by use of the "fountain-pen" size pocket flash light, as well as by the various attached 110-volt models. The Klaar head mirror may be had with battery attachment for use of ordinary flash light globes.

Operating Rooms

The operating rooms should be provided with adequate non-flapping window shades for quick darkening. The walls and floor should be of neutral gray or green, a matter which is especially important for the intraocular, intranasal, or endoscopic work.

Nursing Service

The nursing service should include some one or two graduates with experience in handling such cases, so that student nurses will not be pitchforked into the handling of patients or operations without a little preliminary advice. There is altogether too little instruction in the average hospital as to the nurse's duties in special cases. Courses for nurses are too often a tiresome rehash of the staff teacher's ideas as a doctor, without regard to the difference in the nurse's preliminary training and point of view.

Operating Room Equipment

Operating room equipment should include water-pump suction, secured by the attachment of an ordinary filter pump to the non-sterile water supply. The suction attachment of the filter pump should be attached to a line of one-fourth-inch gas pipe, along the baseboard, terminating in an ordinary gas attachment cock by the head of the operating table. Rubber tubes connecting the gas cock with a large saliva bottle, thence to the operative field, will permit the use of tips for the pharynx, antrum, esophagus, bronchi, or pleura; as well as for the suction-fixation cataract operation. This silent water suction is much preferred by anesthetists, as it obviates the rattle and the buzzing of the electric pumps, which so often prevents proper hearing of the patient's respiration. Compressed air is a useful addition to the anesthetist's outfit, since it does away with the foot pump.

Instruments

Instruments require special care. Unless a special surgical nurse is on service, the surgeon will do well to see after his own eye knives.

Furniture

Furniture should include: a straight high-backed chair, or better a chair with adjustable head rest, for throat work; and a table which can be put up into a half-sitting position for intranasal work. A rather high table is desirable for endoscopy, mastoids, or eye surgery. To avoid motion of tables, two large door stops should be bolted to the table legs and snapped down when patient is ready. Instrument tables should include one long enough to hold bronchoscopic and esophageal instruments without projecting.

Operating Lights

Operating lights should be simple and easily replaced. The Shanan eye lamp may be mounted on a wall bracket or floor standard, and is based upon an ordinary automobile spotlight lamp, run by a small transformer from the house current; or it may be run off an automobile storage battery at 12 volts. The same shadowless lamp may be mounted on a headband in a cup shade and used for throat work. Also a two-inch round frosted 25-watt mazda lamp may be placed in a so-called candelabrum socket, and mounted on a headband in a cup shade. The advantage of using cool lamps which one may buy at any garage or electric store should be obvious. A few extras should be kept on hand. A magnet for intraocular foreign bodies, with its correlated localizer in the X-ray department, will require direct current, and should be as large and powerful as possible. Such equipment will be of use only to the largest hospitals handling many industrial accidents.

Drugs

Drugs should be made up in small quantities. Many newer antiseptics are unstable, and should not be made in stock solutions. A good rule always is: *Fresh for each case.*

Supplies

Supplies should be of agreed patterns. To avoid slashing large gauze sponges, small oval eye pads of cotton with gauze covering, and small oblong ear sponges should be made. Cotton in two-inch square packets, not scissors-cut but pulled smooth, and fourth-inch and half-inch plain packing in tubes, are economical supplies. Use of cotton-ball and gauze-ball throat sponges is kept to a minimum by suction cleansing. Wooden

applicators and tongue depressors, as well as the other supplies mentioned, are best put up in small numbers in paper wrappers; this avoids collecting and washing many small cloth covers.

Dressing Rooms

Dressing rooms should have small quantities of these needed supplies, as well as small kits of sterile examination instruments for ear, nose, or throat. Besides specula, these should include paracentesis knife, ear curette and forceps, and squared steel-wire applicators. Head mirror and drop light with powerful frosted or daylight blue globe should be in the same drawer. Every man doing special work will recall the waste of valuable time while hunting up superannuated, locked-up instruments, running after supplies to the surgery, looking all over the house for the only nurse who has the key, and so on.

Hospital management can have no better function than the correlation of departments of service so that time will be saved, not only for the doctor and his consultants, but also for the nursing staff, and indirectly for the patient.

*THE ESSENTIALS FOR EFFICIENT LABORATORY SERVICE

WYNDHAM B. BLANTON, M.D., Richmond, Virginia
Instructor in Medicine, Medical College of Virginia, Visiting Physician Hospital Division Medical College of Virginia, Consulting Physician Grace Hospital

THE habit of placing laboratories in basements or in odd places for which no other use can be found appears ill advised. The laboratory site should be carefully chosen for its accessibility, abundant supply of northern light, and as a pleasant place in which to work. The nearer the work is done to the patient and to the clinician or surgeon the better. Most large hospitals are equipped with ward laboratories in addition to a central laboratory. This scheme was successfully carried out in the army hospitals. The clinician or surgeon will not walk through long corridors to a distant laboratory, but he will quickly form the habit of stepping into the adjoining ward laboratory to see his blood counts, pus smears, or sections of tissue.

Scope of Work

This depends on the size of the hospital, the amount of money available, and the ideals of the staff. It should be broad and ever broadening. Every laboratory should be worked for all that is in it. No piece of laboratory work should be requested unless there is a reason given. Clinicians should be constantly endeavoring to avail themselves to the fullest extent of this service.

The work of the laboratory may be subdivided as follows:

(1) Clinical Pathology—as blood counts, urinalyses, stools, gastric analyses, etc. In large hospitals this type of work is best done in small rooms on the same floor with the patients.

(2) Serology—as the complement fixation for syphilis, gonorrhea, and tuberculosis, etc.

(3) Bacteriology—as smears and cultures of blood, urine, stools, spinal fluid, etc. Hospital diagnosis should not stop with morphological diagnosis, but the material should be put through sufficient cultures and subcultures to properly identify all organisms.

(4) Chemistry—of blood, urine, spinal fluid, etc.

(5) Pathology—(a) Surgical pathology—a gross and microscopic study of every specimen is not too ambitious a program for any hospital. (b) Autopsies—it has been repeatedly shown that we fail to get autopsies most often when we do not ask for them. Even hospitals dealing exclusively with private patients should have their yearly quota of autopsies. There should be a well equipped autopsy room in every hospital.

Personnel

With rare exceptions it is impossible to conduct a laboratory properly without expert medical supervision. To turn laboratories over to internes and technicians is wrong. The work is too serious and the chances of error are too great.

It never pays to employ a cheap technician. The market is flooded with poorly prepared technicians, who after a Cook's tour through some laboratory—six weeks or six months it may be—set themselves up to do this highly technical work. Character is most essential in the choice of a technician, because laboratory work must stand on intellectual honesty—garden variety of honesty if you will. Technicians must have a sense of responsibility. They should dread an error and be ashamed of it. Their training should never be less than a year or two in a good laboratory. Internes do excellent laboratory work under supervision, if their service is rotating and they are not

* Read before the Virginia-West Virginia Sectional Meeting American College of Surgeons, Jefferson Hotel, Richmond, Virginia, May 2–3, 1924.

kept too long. Internes who are not interested in laboratory procedures do not do as good work as technicians.

Routine Examinations

We are all committed to the necessity for routine in laboratory examinations. The disadvantages are obvious. It kills initiative and tends to leave the laboratory sense undeveloped in the clinician. Much unnecessary work is done. On the other hand, it is easy and safe, and these things count in hospital medicine. What should be the routine? Theoretically those examinations which throw the most light on the greatest number of clinical problems, provided they can be done quickly and easily. It is the dragnet method of diagnosis. The net, however, must not be too small, nor must it be too cumbersome.

What then should constitute the laboratory work done on admission? A urinalysis, blood count, and Wassermann. For each of these there is a very definite reason. The urine uncovers (a) Nephritis, causing 100,000 deaths yearly in the United States; (b) Diabetes, estimated by Joslin as occurring in one of every one hundred persons in the United States; (c) The often obscure infections, injuries, and neoplasms of the genito-urinary tract. The blood count gives indispensable information in the great volume of infections encountered every day, not to mention the important dyscrasias of the blood. The Wassermann unearths syphilis—so often occult, and estimated by Hazen as occurring in ten per cent of the population of the United States.

Why not include a sputum examination, or the stool, or spinal fluid? Tuberculosis is a more frequent disease than nephritis, but a single sputum examination would reveal it rarely in routine general hospital admissions. The consequences and probabilities of stool abnormalities are vastly disproportionate to those of a urinalysis, blood count, or Wassermann. This also applies to the spinal fluid. Routine is so important as a time and error saver that I believe it should not stop with admission work. There should be routine subsequent work, based on the preliminary clinical survey of the case. Thus there should be a diabetic, a nephritic, a prostatic, a gastrointestinal routine based on the line that the case seems to follow. For instance, the patient has high blood pressure, casts, and albumen. The second routine should automatically care for him. A phthalein, a blood chemistry, a twenty-four-hour urine for chlorides and fractional specific gravity and quantity study should be done on one order as soon as nephritis is a probable diagnosis.

System of Charges

The laboratory man regards himself as a pure scientist, and scientists, as such, are notoriously poor business men. The commercial laboratory smacks of something that runs counter to the best instincts of the real scientist. He cannot exactly come to the point of bartering his services. He is more afraid of cheapening his profession than of dying poor. There are real dangers arising from the commercialization of the laboratory, and of the appearance of men in this field of medicine who have too much of an eye for business and money. There is a movement on foot in France to stop the exploiting of the public by private laboratories of the poorer sort by requiring Government supervision.

In making charges for laboratory work I think it is essential for hospitals to keep the fee as low as possible. Patients do not see the work done. They do not know what is entailed in laboratory work and are therefore apt to object to laboratory charges. If charges are high doctors will not request laboratory work, in an effort to save the patients this expense. Small laboratory fees promote freer use of the laboratory and better professional work in the hospital.

Great variation exists in the matter of laboratory charges by hospitals. A few hospitals make no charge, as the New York Hospital. Others charge a flat fee on admission, which covers all the work that may be done on the patient during his stay in the hospital. This is the practice of the Michael Reese Hospital in Chicago, as well as of several hospitals here in Richmond. The more usual custom, however, is to make a routine admission charge with additional charges for additional work.

I believe a small fee should be charged on admission to cover the routine laboratory work; that this fee should vary for private and ward patients, and that there should be a different charge for tonsil cases than for those admitted to the medical, surgical, or obstetrical services. All repeated examinations should be made for one-half or less than the schedule tariff. Special laboratory work over and above the admission routine should be charged for according to a printed schedule of laboratory fees. And finally, I think it well to have a schedule of special rates for consolidated work, adapted to meet the routine requirements of common well known diseases, as nephritis, diabetes, etc., and of patients for prostatectomy, etc.

Records

Too much stress cannot be put on recording laboratory work. What is worth doing is worth

recording. The essentials of good laboratory records are *accuracy, clarity, simplicity, fullness without prolixity, and legibility.* The work should be recorded as it is done and not from memory. The records should be free from abbreviations. They should be in good King's English, following standard pathological nomenclature. They should be written on the typewriter or in ink. They should all be signed by the person doing the work. The important work should be initialed by the responsible head of the laboratory. It is well to have the time at which the work is requested recorded, as well as the date and time that it is reported. Laboratory work requiring several days for completion should be reported as it advances in the form of preliminary reports. Laboratory reports should contain no speculations. They should report simply the findings. Requests for laboratory work should come to the laboratory on forms which reveal information of importance about the clinical aspect of the patient. Laboratory reports should be made on one standard form, which should be finally attached to the clinical record. They should be made to conform to the general size and shape of the rest of this record, to admit of ease in binding. Duplicate records of all laboratory work should be kept in the laboratory either on cards or in book form.

*ESSENTIALS FOR EFFICIENT X-RAY SERVICE

PATRICK F. BUTLER, M.D., BOSTON

Radiologist, Boston City Hospital

ROENTGEN RAY work has changed so in the last few years that it has now become a very highly specialized field, both in its technic and in its medical interpretation and application. The mere possession of an X-ray machine, despite the arguments advanced along this line by the manufacturers, gives no more right to a man to do X-ray work than the possession of a scalpel gives a physician the right to do major surgery. In all our large hospitals and laboratories this work is now carried on by highly trained physicians and technicians. The equipment and apparatus shows marked advances each year and these advances must be kept up with in order to do the most approved work. Of course, this cannot be done without the expenditure of considerable money, even when the utmost economy is used.

ORGANIZATIONS

In the organization of a hospital laboratory there must be a chief, with medical assistants, medical house officers and technicians, depending on the size of the clinic. In some cases the chief should be a man who gives all his time to the laboratory, but this means a substantial salary with the privilege of charging private patients; often this scheme is not practical and the problem is solved by a part-time man, who may still carry on his private practice. Both arrangements have worked out satisfactorily and each is receiving try-outs in various hospitals.

The chief is responsible for all work turned out, materials used, up-keep of apparatus, selection of house officers, and safety of patients and working force. He should have the necessary medical assistants and so sub-divide the work of the clinic that each assistant is responsible for his particular division. In our department the clinic is divided into a chest division, a treatment division, a gastro-intestinal tract division, and a general bone division, with a physician in charge of each. One assistant physician is responsible for all material bought and used and makes a monthly report to the chief. Another assistant is responsible for the proper up-keep of all apparatus and meters. The third assistant is in direct charge of all the help. Our chief and medical assistants give half of their working day to the clinic and receive a substantial honorarium.

Technicians may be male or female; it has been our experience that hospital work is too exacting and trying for female technicians, and I have found that the male technicians accomplish more work, even though they are not as amenable to discipline. It is customary to start a green man and develop him in the various branches of the work, so that at the end of two years a technician is able to handle any of the machines. We have meetings of all the technical staff frequently, at which times physicians explain the theory, practice, and dangers of the work. It is also advisable from time to time to impress upon the technical force their own responsibility and thus keep them on the alert for any accidents that might occur. We are often asked where good technicians may be obtained; there is now being established a registry for technicians by a joint committee of the American Roentgen Ray Society and the Radiological

*Read before the New England Sectional Meeting of American College of Surgeons, Providence, R. I., May 8–9, 1924.

Society of North America. Here competent registered technicians may be obtained.

The training of house officers must, of course, be carried on if we are to have capable men trained to meet the ever increasing demands of the profession. We give a man a year's internship, starting him in first on technic and simple diagnosis, then increasing the responsibility and work, trying to give him a complete versatile course in X-ray diagnosis and therapy. House officers differ, and, naturally, the man gets most out of his work who puts the most in.

Equipment

The choice of apparatus depends largely on the type of clinic. A general clinic requires several different types of apparatus, and it is advisable to have separate rooms, where possible, for gastro-intestinal work, chest work, and renal work. The installation of apparatus should be carefully supervised by a physician conversant with all the dangers of the work and not left to the dealers. In some smaller institutions the use of self rectifying tubes, which do not require a motor, may work very satisfactorily. In our new installation we have used the standard tubes with a motor driven rectifying device in almost every room, feeling that the limitations of the radiator tube render it less serviceable for general use by technicians, who are none too careful. We have also several portable machines with which we are able to take care of very sick patients in the wards without bringing them to the department.

It is advisable to make of each room a separate X-ray unit and have it wired directly to the main switch-board, so that its current is independent of the connections to any other room. Each room should be capable of radiographic or fluoroscopic work, and this necessitates the facilities for making every room a dark-room when necessary. The day has now passed when X-ray departments are to be placed in basements; it is now a generally recognized fact that expensive, complicated apparatus of an X-ray department should never be placed in basement rooms. The amount of floor space required differs according to the needs and amount of help available. We estimate that for a hospital of 1,000 beds about 12,000 square feet are needed and for smaller hospitals a proportionate area is necessary.

For dressing rooms the best plan is a row of steel lockers adjoining a small dressing room; the patient undresses in the dressing room, then puts on his hospital gown and places his clothing in one of the steel lockers and locks it. This arrangement does away with the necessity of large dressing room space. It also prevents theft of clothing and contamination of one patient's clothing by an unclean patient's clothing.

Danger

Because of the well recognized electrical dangers, certain requirements are laid out by the Safety Committee of the Roentgen Ray Societies of this country and England. These safety requirements call for the following regulations:

1st. No one machine should furnish power to more than one room.

2nd. All the rooms should be exposed to sunlight.

3rd. Ample ventilation from out doors is necessary.

4th. Generous amounts of sheet lead should surround each room which contains an active X-ray tube.

5th. All exposure switches must be outside the exposure room.

6th. All floors should be constructed of an insulating material, such as cork, wood, or linoleum and all metal machines should be properly grounded.

If these regulations are followed and machines and accessories properly supervised by a physician, electrical accidents should be prevented.

In our time the danger from X-ray burns is almost entirely confined to the treatment clinic, and with this apparatus considerable precaution must be taken, although with the proper medical supervision and care there should be no trouble. A treatment should always be planned by a physician or house officer and the settings, filters, and distances should then be checked by another person before the treatment is started. The operator should never leave the machine, where he can can watch both the patient and the meters, until the treatment is finished. It is also advisable to have the patient hold a push botton or some other sort of signal device to warn the operator, if it becomes necessary, to stop the treatment.

Care and Up-Keep

The care of machines should be under the supervision of one of the physicians. All meters should be calibrated once a week and checked with a standard meter. All reels and trollies should be personally inspected by a physician and all imperfect parts should be repaired or replaced at once. The motors and transformers should be inspected every month by a mechanic from the manufacturers. Oiling and cleaning can be taken care of by the technician in charge of each individual machine. These technicians should dust

the tubes every day and cover them carefully at night to protect against dust and moisture.

Dark-Room

A large part of the time of the X-ray force must be given to the care and handling of films. Most of this work is done in the darkroom and is not seen or appreciated by visitors to an X-ray department. The dark-room itself should be of ample size and well ventilated. The old custom of painting the dark-rooms black has disappeared and now the light colors are used. The developing tanks should all be large, for small tanks are the chief cause of scratched and marred films. All electrical fixtures should be porcelain rather than metal because a technician may receive a severe shock if his wet hands come in contact with the charged metal. Wall switches are not advisable because of the danger of shock to the wet hands and also because the wall surrounding the switch soon becomes soiled by the technician feeling for the fixture in the dark. The best arrangement for lighting the dark-room is by pull cords hanging from the ceiling fixtures. Intensifying screens are best handled in a special dark-room away from the moisture. Loading benches for films should be as far removed as possible from the developing end of the dark-room, to prevent wet hands coming in contact with them. These benches should be at least two feet wide. Racks for developing frames are best placed above the loading bench and on simple brackets of various sizes. The dark-room floor should be washed every day because spilled hypo-sulphite of sodium soon crystallizes on the floor and is then kicked into the air as dust and may settle on exposed films or screens. Developing tanks and fixing tanks should be kept covered when not in use. This prevents evaporation and contamination of these solutions. New films are best stored in cabinets in the dark-room or in an adjoining stock-room, and must be well protected from X-rays by lead walls. Developed films, when possible, should be dried outside the dark-room; any simple cabinet with continuous circulation of air, induced by electric fans, will dry a large number of films in an hour. Because of the serious fire hazard caused by a large number of inflammable films, it is advisable to store all films in ventilated, fire-proof cabinets. A recent announcement from the manufacturers states that in a short time they will have ready a non-inflammable film, which should solve this difficulty. Another annoying problem is the loss of finished films from the record room. These films are taken to the bedside for convenience of the attending surgeon or to the operating room, and are frequently misplaced and lost, despite the fact that house officers do sign a requisition before they remove films from the department. My own feeling is that no films should be allowed out of the department and that the visiting physicians should all come to the department to view the cases in which they are interested. A possible solution for this is to make prints of the interesting cases and attach these to the clinical records, keeping the original films in the department. It is our custom to retain films in the files for seven years, the legal limit for law suit in Massachusetts, and then to discard them.

Expense

Good apparatus is expensive, but essential for proper and up-to-date work. The maintenance of an X-ray department also is expensive but there are several causes for this which well may be eliminated or cut down. The principal causes of needless expense are:

1st—Examinations referred by friends of the hospital.

2nd—Misrepresentation of patients' ability to pay.

3rd—Unnecessary examinations.

In our experience, the abuse of the department by friends of the hospital and politicians is a negligible factor, although the contrary is generally believed. Misrepresentation by patients of their ability to pay is, of course, a serious consideration in all hospitals; it is very difficult to handle this situation, because the patients may lie in order to get a free or cheap examination. The principal means of cutting down expense is to eliminate unnecessary examinations, which are the greatest cause of needless expenditure. From a careful review of our last thousand gastro-intestinal examinations I satisfied myself that 30% of these examinations were unnecessary and uncalled for. The solution of the latter difficulty is a hard one. We have tried to establish in our out-patient department a clearing house for gastro-intestinal cases; every patient referred from the out-patient department must go to this room and satisfy the executive in charge that such an examination is essential for diagnosis. A satisfactory method might be to have a physician who appreciates the difficulties of both the X-ray department and out-patient clinic act as an executive, with the power to decide on the necessity of such examinations. Unfortunately, at the present time, many busy house officers and physicians do not spend sufficient time in the preparation of their cases and are too prone to shift the problem along to the X-ray department,

when a careful history and physical examination would convince them that X-ray was not called for. One remedy for cutting down expense is to use the fluoroscope more and films less; this presupposes, of course, considerable skill on the part of the physician making the fluoroscopic examinations, but it is bad judgment to limit the examination of gastro-intestinal cases to the fluoroscope alone. The best way for cutting down unnecessary waste is probably to be found in the closer co-operation of the clinical staff with the X-ray department and a greater appreciation of the difficulties of X-ray work on the part of the hospital physicians.

SUMMARY

The following points summarize the entire subject:

1st. A carefully chosen, thoroughly trained staff of physicians and technicians is essential.

2nd. Proper apparatus properly installed must be used.

3rd. The safety rules of the American Roentgen Ray Society should be observed carefully.

4th. A special executive, X-ray physician should pass on the necessity of all examinations.

5th. Closer co-operation between the clinical staff and the X-ray department would probably eliminate much of the present unnecessary waste.

A CASE OF ACTINOMYCOSIS HOMINIS

WILLIAM T. HENDERSON, M.D., F.A.C.S., MOBILE, ALABAMA

Visiting Surgeon, Providence Infirmary, Mobile City Hospital

THE patient, J. C., was admitted to Providence Infirmary August 12, 1925. Age 53; race white; occupation teamster:

PAST HISTORY OF PATIENT: Previous to present illness general health was good, no trouble other than occasional indigestion. Was very healthy as a child with no serious illness. Had typhoid since grown, and a mild attack of influenza in 1918. Has had no trouble from eyes, ears, nose, or throat. No history of tonsillitis. No specific disease. No history of cardiac or respiratory disorders. Habits normal. Appetite good. Drinks coffee moderately. Belches sour food after meals. Hours regular. Sleeps well. Bowels move at least once daily. Kidneys act freely, several times a day. No history of kidney or bladder stones. No discomfort in micturition.

PRESENT CONDITION: Illness began four months previous to admission to hospital. On examination of the right upper jaw a tumor was found involving the malar bone and the right superior maxillary. All of the patient's teeth had been removed previous to his admission to the hospital in an effort to relieve him of intense pain. Abscess formation had destroyed the greater part of the alveolar process and a part of the palate process. There were several discharging sinuses along the margin of the inner border of the alveolar process. A straw colored inflammatory exudate could be seen extruding into the mouth. These openings were evidently the results of various efforts made to drain abscesses which had formed along the border of the alveolar process. The skin over the malar bone was edematous, red in color, and readily pitted on pressure. This edema extending to the lower eye-lid, though the redness did not extend inward toward the eye.

The X-ray picture gives evidence of a tumor of considerable proportion which involves the right maxillary and the malar bone.

A microscopical examination made of the discharges obtained by the curette from the sinuses entering into the mouth shows plainly a case of actinomycosis hominis.

At the operation the "Fergusson" incision was used, the skin being reflected back on the right side of the face, care being taken when the incision was made along the lower border of the orbit that the lacrimal sac and its duct were not injured. The incision then followed down along the side of the nose reflecting beneath the wing of the nose, to divide the upper lip at its center. We found, after dissecting the skin back, that it was not affected by the extension of the fungus in this direction, that the redness and edema were the result of inflammatory process—a secondary infection. With a sharp chisel the orbital process of the superior maxillary bone was carefully divided, and likewise the nasal process was left in situ. The soft parts over the palate process within the mouth were carefully injected with a weak solution of epinephrin, so as to lessen the hemorrhage as much as possible, when the incision was made over the junction of the two bones within the mouth. As soon as the soft parts of the palate were divided these were reflected outward, or towards the diseased parts. A gigli saw was now passed through the nostril on the right side and

the bone readily severed from the opposite side. The next step in the operation was to cut off with a sharp chisel the anterior end of the zygomatic process of the temporal bone just beyond its articulation with the malar, as this bone was involved in the fungoid growth. It was now an easy matter to take hold and lift it out of its bed with what appeared to be all of the diseased tissue.

The after treatment in this case consisted of iodide of potash to the point of tolerance, which at this date seems to be 60 grs. three times a day, and the application of the X-ray over the surface previously occupied by the diseased bone. It is claimed by authorities that the application of these rays will liberate nascent iodine in the tissues and so destroy the ray-fungus, and with this object in view we are also applying tincture of iodine to the raw surface within the mouth. We know from experience that the X-ray will destroy the fungus which is the cause of epidermomycosis and that it will inhibit the growth of the fungus of blastomycosis in the skin, and we trust that the frequent application of the X-ray in this interesting disease will restore our patient to health, though it is too soon to report here the end results in this case.

BEQUESTS

THE College has much pleasure in acknowledging through its Bulletin two bequests of which the Board of Regents has been informed.

Through an interest in the College, inspired in one of her patients by one of our Fellows of Boston, we will receive at some future time $50,000 for surgical research.

By the will of Dr. John S. Jenkins, of Pine Bluff, Arkansas, the College is to receive, upon the death of himself and his wife, his library and orthopedic equipment, and a fund of $15,000 which is to establish in perpetuity the Doctor John S. Jenkins Memorial, through which a research in orthopedics and plastic surgery is to be maintained by the Research Department of the College.

As occasional inquiries have come to us regarding the manner in which bequests of varying amounts should be left to the College, it has occurred to the Board of Regents that there may be opportunity for Fellows of the College to interest their philanthropically inclined friends or patients in the varied humanitarian activities of the organization, and thus secure their support, either for the permanent Endowment Fund, or for clinical research—general or specific. This will serve also as a reminder to our Fellows for purpose of such bequests as they themselves may desire to leave to their College.

HOSPITAL STANDARDIZATION CONFERENCE

In the Ballroom of the Bellevue-Stratford

Monday, October 26—Morning Session, 10:00 to 12:30

Charles H. Mayo, M.D., Rochester, President, Presiding

Opening Address by the President.

Presentation of the Eighth Annual Report of Hospital Standardization. Franklin H. Martin, M.D., Chicago; Director-General, American College of Surgeons.

The Responsibility of the Fellows of the American College of Surgeons in Hospital Standardization. LeRoy Long, M.D., Oklahoma City, Okla.; Dean and Professor of Surgery, University of Oklahoma School of Medicine.

The Hospital, the Doctor, and the Nurse as Co-operating Factors in the Care of the Patient. W. T. Henderson, M.D., Mobile, Ala.; Visiting Surgeon, Providence Infirmary and Mobile City Hospital.

The Eminent Hospital. Rev. C. B. Moulinier, S.J., Milwaukee; President, Catholic Hospital Association

What the American College of Surgeons Can Do for the Smaller Hospital. Paul H. Fesler, Oklahoma City, Okla.; Superintendent, State University Hospital.

Hospital Efficiency from the Viewpoint of the Internist. Alfred T. Stengel, M.D., Philadelphia; Professor of Medicine, University of Pennsylvania; President, American College of Physicians.

Political Interference in Hospitals. Rudolph Matas, M.D., New Orleans; Professor of Surgery, Tulane University of Louisiana School of Medicine; President-Elect, American College of Surgeons.

Afternoon Session, 2:00 to 5:00

The Future of Hospital Standardization. Newton E. Davis, Chicago; President, American Protestant Hospital Association; Corresponding Secretary, Board of Hospitals, Homes and Deaconess Work of the Methodist Episcopal Church.

The Application of American College of Surgeons Standards in the Modern Hospital. H. L. Foss, M.D., Danville, Pa.; Surgeon-in-Chief, Geisinger Memorial Hospital.

Essentials for an Efficient Fracture Service in a Hospital. Charles L. Scudder, M.D., Boston; Consulting Surgeon, Massachusetts General Hospital.

End-Results and Follow-Up. Henry L. Page, M.D., Philadelphia; Medical Director, Lankenau Hospital; and Miss Annie M. Jastrow, Philadelphia; Director of the Follow-up Service, Lankenau Hospital.

Postmortems in Hospitals

Findings in the State of Pennsylvania Survey. Frank C. Hammond, M.D., Philadelphia; Dean and Professor of Gynecology, Temple University Department of Medicine.

Relation of the Surgeon to Postmortems. Charles Bagley, Jr., M.D., Baltimore; Associate in Experimental Neurology, Johns Hopkins University Medical Department.

Postmortems in the Open Hospital. Israel Brown, M.D., Norfolk, Va.; Surgeon, St. Vincent's Hospital and Sanitarium.

General discussion.

Tuesday, October 27—Morning Session, 10:00 to 12:30

Group Conference on Medical Service in Hospitals—Ophthalmology and Otolaryngology. James A. Babbitt, M.D., Philadelphia, Associate Professor of Otolaryngology, University of Pennsylvania Graduate School of Medicine, presiding. Topics for discussion: Minimum requirements for ophthalmological and otolaryngological departments in general hospitals. Need for ophthalmological and otolaryngological departments in general hospitals in a community where there is no special hospital for the purpose. Special physical features to be considered in planning the department; accommodations

for patients, rooms, and wards; examination, treatment, and operating rooms. Standardization of equipment, supplies, and procedures. Organization of the department, relation to general organization, medical and nursing. Relation to allied services—clinical laboratory, X-ray, anæsthesia; requisitioning for clinical laboratory and X ray service; routine clinical laboratory, pre-anæsthesia and pre-operative examination; special X-ray technique required. Case recording, forms used, content of records, securing of records, supervising of records, filing and cross indexing of records, use of records.

General discussion.

Afternoon Session, 2:00 to 5:00

The Rôle of the Medical Staff in Hospital Efficiency. J. Garland Sherrill, M.D., Louisville; Professor of Surgery, University of Louisville Medical Department.

Round Table Conference. Conducted by Joseph C. Doane, M.D., Philadelphia, Medical Director and Superintendent, Philadelphia General Hospital. Topics for discussion: Responsibility for preoperative preparatory procedures; The relations and responsibilities of the interne; Instruction of internes and nurses; Economies in the surgical department; Concurrent surgical services; Post mortems on the surgical service; Open versus closed hospitals; Hospital extra charges; The hospital trustee; Extending privileges to doctors to practice in a hospital.

General discussion.

Wednesday, October 28—Morning Session, 10:00 to 12:30

Group Conference on Medical Service in Hospitals—Internal Medicine. Alfred T. Stengel, M.D., Philadelphia, Professor of Medicine in University of Pennsylvania, President of American College of Physicians, presiding. Physical requirements to be considered in hospital planning from the standpoint of the internist; The organization of a department of clinical medicine, (a) Medical staff, (b) Interne, (c) Nursing personnel; Relation of special departments to internal medicine, (a) Clinical laboratory, (b) X ray, (c) Metabolism, (d) Electro-cardiograph, (e) Dietary department; The staff conference: (a) General, (b) Departmental; Case records as related to correlation of facts pertaining to diagnosis, progress, and end results of non-surgical patients; The establishing and maintaining of co-operative relations between internal medicine and other clinical services.

Pathological Conferences in Standardized Hospitals—Herman Spitz, M.D., Nashville, Tenn.; representing the American Society of Clinical Pathologists.

General discussion.

Afternoon Session—2:00 to 5:00

Systematic Collection and Official Publication of Operative Mortalities as a Means of Fostering Surgical Accountancy. Robert L. Dickinson, M.D., New York, Senior Gynecologist and Obstetrician to Brooklyn Hospital.

Round Table Conference. Conducted by John D. Spelman, M.D., New Orleans, Superintendent of Touro Infirmary. An opportunity will be given to all to present any questions to the Conference which they wish discussed. In addition, a large number of questions already sent in will be discussed so far as time permits.

ANNOUNCEMENT

Information regarding reduced railroad rates, special trains from Chicago, and Philadelphia hotels, will be found on pages 21 and 22. No registration fee is required for attendance at the Hospital Conference.

CLINICAL CONGRESS OF AMERICAN COLLEGE OF SURGEONS

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FRANKLIN H. MARTIN, Chicago, *Director-General*

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PROGRAM FOR THE CLINICAL CONGRESS IN PHILADELPHIA

THE fifteenth annual Clinical Congress of the American College of Surgeons will open at 10 o'clock on Monday morning, October 26 at the Bellevue-Stratford Hotel in Philadelphia with the annual hospital conference. At the presidential meeting on Monday evening, the first formal session of the Congress, the President-Elect, Dr. Rudolph Matas of New Orleans, will be inaugurated, succeeding Dr. Charles H. Mayo in that office. The John B. Murphy oration in surgery will be delivered at that session by Sir William Arbuthnot Lane of London, England.

Clinics and demonstrations at the hospitals and medical schools will provide an interesting program for the mornings and afternoons of the four days, Tuesday to Friday, inclusive, with scientific sessions each evening. For these evening sessions the Executive Committee of the Congress has provided programs of unusual interest. A complete program for the evening sessions will be found in the following pages. At the convocation of the College on Friday evening the Fellowship Address will be given by Lord Dawson of London, England, physician to King George.

The Committee on Arrangements, of which Dr. Charles F. Nassau is Chairman and Dr. Warren B. Davis Secretary, has prepared a program of clinics and demonstrations that will surpass in scientific interest all previous sessions. The preliminary clinical program is being reprinted in this issue. This program will be revised and amplified previous to the meeting, so that the actual program will fully represent the clinical activities in all departments of surgery. The real program of the Congress is to be issued daily during the session giving in complete detail a description of the clinics and demonstrations at the several hospitals and medical schools. This program will be issued in the form of bulletins posted each afternoon at headquarters for the following day's clinics. A printed program will be issued each morning.

An important feature of the program will be a series of clinical demonstrations or "dry

clinics" at a number of the hospitals in which surgeons, internists, pathologists, roentgenologists, and other specialists will participate to discuss some of the more important phases of surgery.

Of special interest to those engaged in the practice of ophthalmology and otolaryngology is the program of papers and demonstrations prepared by the Committee to be given in the Ballroom on Wednesday, Thursday, and Friday mornings at nine o'clock supplementing the clinical work in the hospitals in the afternoon.

General headquarters of the Congress will be established at the Bellevue-Stratford Hotel, Broad and Walnut streets, where the entire first floor, including the Ballroom, Clover, Red, Pink, and Gold rooms, together with the Stratford Room on the main floor and the Rose Garden and other rooms on the roof, have been reserved for the exclusive use of the Congress. These rooms provide ample space for evening meetings, business sessions, hospital standardization headquarters, registration and ticket bureaus, bulletin rooms, etc. Headquarters will be open for registration at eight o'clock on Monday, October 26.

The clinical program for Tuesday will be posted on bulletin boards at headquarters during Monday afternoon and reservations for tickets for Tuesday's clinics may be filed late that afternoon.

The annual meeting of the Fellows of the College will be held in the Ballroom of the Bellevue-Stratford on Thursday afternoon at three o'clock to be followed by the annual meeting of the Board of Governors.

Since the last session of the Congress in Philadelphia in 1921 there have been erected in that city a number of fine, large hotels situated within easy walking distance of the Bellevue-Stratford, so that the hotel situation in that city has been greatly improved. A list of the Philadelphia hotels recommended by the Local Committee on Arrangements, together with the rates, will be found on another page.

HOSPITAL CONFERENCE

The preliminary program for the annual hospital conference to be held on Monday, Tuesday, and Wednesday, both mornings and afternoons, at the Bellevue-Stratford will be found in the pages following. Addresses, demonstrations, round table conferences, and general discussions by surgeons, superintendents, trustees, nurses, and others interested in the conduct of hospitals deal intimately with the details of hospital standardization and management, providing a program of very great interest and practical value in treating many of the everyday problems and difficulties encountered in hospital management and the care of the patient within the hospital.

At the opening session on Monday morning, Dr. Franklin H. Martin, Director-General, will present his report including a list of the hospitals which appear on the approved list for the year 1925.

A hospital information and service bureau, in charge of Dr. M. T. MacEachern, Associate Director in charge of hospital standardization activities, will be maintained in the Congress headquarters throughout the session to give assistance to any hospital seeking solutions of its troublesome problems. All who are particularly interested in hospital problems are requested to register at hospital standardization headquarters upon arrival at Philadelphia. A general invitation is extended to hospital trustees, members of the medical and surgical staffs, and hospital personnel generally to attend the conference.

REDUCED RAILWAY FARES

The railways of the United States and Canada have authorized reduced fares on account of the Philadelphia session of the Clinical Congress, so that the total fare for the round trip will be one and one-half the ordinary first-class one-way fare. To take advantage of the reduced rates it is necessary to pay the full one-way fare to Philadelphia, procuring from the ticket agent a "convention certificate" when purchasing such ticket, which certificate is to be deposited at headquarters for the visé of the special agent of the railway companies. Upon presentation of viséed certificate to the ticket agent in Philadelphia not later than November 3 a ticket for the return journey by the same route as traveled to Philadelphia may be purchased at one-half the regular one-way fare.

In the eastern, central, and southern states and eastern provinces of Canada tickets may be purchased between October 22 and 28; in southwestern and western states between October 21 and 27 and in the far western states and western provinces of Canada between October 16 and 22. The return journey from Philadelphia must be begun not later than November 3.

The reduction in fares does not apply to Pullman fares, nor to excess fares charged for passage on certain trains. Local railroad ticket agents will supply detailed information with regard to rates, routes, etc. Stop-overs on both the going and return journeys may be had within certain limits.

Full fare must be paid from starting point to Philadelphia, and it is essential that a "convention certificate" be obtained from the agent from whom the ticket is purchased. These certificates are to be signed by the general manager of the Clinical Congress and viséed by a special agent of the railroads in Philadelphia during the meeting. No reduction in railroad fares can be secured except in compliance with the regulations outlined and within the dates specified. It is important to note that the return trip must be made by the same route as used to Philadelphia and that the certificate must be presented and return ticket purchased not later than November 3.

SPECIAL TRAIN FROM CHICAGO

For the convenience of Fellows residing in the central and western states who will attend the meeting in Philadelphia, the Pennsylvania Railroad will undertake to provide a special train leaving Chicago at 1:15 p.m. on Sunday, October 25, arriving in Philadelphia at 9 a.m. on Monday, October 26. This special train will duplicate the equipment and schedule of the famous Broadway Limited including standard Pullman sleeping, compartment, club, observation, and dining cars. The arrangement is contingent upon reservations for such special train being made by the minimum number required by the Interstate Commerce Commission rules. No extra fare will be charged for passage on this special train. Members are urged to make their reservations for the special train at the earliest possible date.

LIMITED ATTENDANCE

Attendance at the Philadelphia session will be limited to a number that can be comfortably accommodated at the clinics, the limit of attendance being based upon the result of a survey of the amphitheaters, operating rooms, and laboratories in the hospitals and medical schools as to their capacity for accommodating visitors. This plan necessitates registration in advance on the part of all who wish to attend. When the limit of attendance has been reached through advance registration, no further applications can be accepted.

CLINIC TICKETS

Attendance at clinics and demonstrations will be controlled by means of special clinic tickets, which plan has proved an efficient means in the past for providing for the distribution of visiting surgeons among the several clinics and insures against overcrowding, as the number of tickets issued for any clinic is limited to the capacity of the room in which that clinic is given.

Clinic tickets will be issued at headquarters each morning at eight o'clock for the clinics and demonstrations to be given that day. Each afternoon a complete schedule of the following day's clinics will be posted on bulletin boards at headquarters. After the program has been posted, reservations for clinic tickets may be filed, the tickets to be issued the following morning.

REGISTRATION FEE

A registration fee of $5.00 is required of each surgeon attending the annual clinical meeting, such fees providing the funds with which to meet the expenses of the meeting. To each surgeon registering in advance, a formal receipt for the registration fee is issued, which receipt is to be exchanged for a general admission card upon his registration at headquarters during the meeting. This card, which is nontransferable, must be presented to secure clinic tickets and admission to the evening meetings.

PHILADELPHIA HOTELS AND THEIR RATES

	Minimum Rate for Room with Bath	
	Single	Double
Adelphia, Chestnut and 13th Sts.	$4.00	$8.00
Bellevue-Stratford, Broad and Walnut Sts.	5.00	8.00
Benjamin Franklin, Chestnut and 9th Sts.	3.00	6.00
Green's, 8th and Chestnut Sts.	3.50	5 00
Longacre, Walnut St. West of Broad	4.00	6.00
Lorraine, Broad St. and Fairmont Ave.	2.50	5.00
Majestic, Broad St. and Girard Ave.	4.00	5.00
Robert Morris, 17th and Arch Sts.	3.00	5.00
Pennsylvania, Chestnut and 39th Sts.	3.00	6.00
Rittenhouse, Chestnut and 22nd Sts.	3.50	5.00
Ritz-Carlton, Broad and Walnut Sts.	6.00	10.00
Spruce (men only), Spruce and 13th Sts.	4.00	.....
St. James, Walnut and 13th Sts.	3.50	5.00
Stenton, Broad and Spruce Sts.	5.00	7.00
Sylvania, Locust and Juniper Sts.	4.00	6.00
Walton, Broad and Locust Sts.	3.00	5.00

PROGRAM FOR EVENING MEETINGS

IN THE BALLROOM OF THE BELLEVUE-STRATFORD AT 8 O'CLOCK

Presidential Meeting—Monday, October 26

Address of Welcome: CHARLES F. NASSAU, M.D., Chairman of Committee on Arrangements.

Address of Retiring President: The Function of the Liver. CHARLES H. MAYO, M.D., Rochester.

Introduction of Foreign Guests.

Inaugural Address: Personal Experience in the Surgical Cure of Aneurism (illustrated by motion pictures). RUDOLPH MATAS, M.D., New Orleans.

The Doctor John B. Murphy Oration in Surgery: A Tribute to Doctor Murphy. SIR WILLIAM ARBUTHNOT LANE, Bt., London, England.

Tuesday, October 27

CHEVALIER JACKSON, M.D., Philadelphia: Pulmonary Suppuration Due to Foreign Body Contrasted with that of Other Etiology. (Chalk and lantern demonstration.)

VICTOR PAUCHET, M.D., Paris, France: Experiences in the Surgical Treatment of Gastric, Duodenal and Jejunal Ulcers.

Discussion: JOHN H. GIBBON, M.D., Philadelphia.

A. MURAT WILLIS, M.D., Richmond, Virginia: The Mortality in Important Surgical Diseases, Especially Appendicitis.

Discussion: DAMON B. PFEIFFER, M.D., and JOHN STEWART RODMAN, M.D., Philadelphia.

PROFESSOR VITTORIO PUTTI, Bologna, Italy: Congenital Dislocation of the Hip.

Discussion: ARTHUR BRUCE GILL, M.D., and DEFOREST WILLARD, M.D., Philadephia.

Wednesday, October 28

ARTHUR H. CURTIS, M.D., Chicago: Chronic Pelvic Infections: Deductions Resultant from a Combined Clinical and Laboratory Study.

Discussion: CHARLES C. NORRIS, M.D., and P. BROOKE BLAND, M.D., Philadelphia.

W. BLAIR BELL, B.S., M.D., Liverpool, England: The Treatment of Chronic Ascending Infections of the Uterus and Adnexa by the Bell-Beuttner Operation with Ovarian Conservation or Grafting.

Discussion: JOHN G. CLARK, M.D., and BROOKE M. ANSPACH, M.D., Philadelphia.

ROBERT C. COFFEY, M.D., Portland, Oregon: The Principles of the Radical Treatment of Cancer of the Organs Located in the Pelvis.

Discussion: JOHN B. DEAVER, M.D., Philadelphia.

Thursday, October 29

Symposium on the Rehabilitation of the Handicapped Surgical Patient:

Patients Suffering from Lesions of the Stomach and Duodenum: GEORGE B. EUSTERMAN, M.D., and DONALD C. BALFOUR, M.D., Rochester, Minnesota.

Patients Suffering from Goiter: ROBERT S. DINSMORE, M.D., Cleveland.

Cardiorenal Cases: FRANK H. LAHEY, M.D., Boston.

Patients Suffering from Urinary Obstruction: HERMON C. BUMPUS, M.D., VERNE C. HUNT, M.D., and WALTMAN WALTERS, M.D., Rochester, Minnesota.

The Use of Insulin in Surgery and Obstetrics: F. N. G. STARR, M.D., Toronto, Ontario.

Discussion: FREDERICK G. BANTING, M.D., Toronto, Ontario.

General Discussion: GEORGE P. MULLER, M.D., and JOHN H. JOPSON, M.D., Philadelphia.

Convocation—Friday, October, 30

Invocation.

Conferring of Honorary Fellowships.

Presentation of Candidates for Fellowship.

Presidential Address: RUDOLPH MATAS, M.D., New Orleans.

Fellowship Address: THE RIGHT HON. LORD DAWSON OF PENN., G.C.V.O., K.C.M.G., C.B., M.D., London, England, Physician in Ordinary to H. M. the King.

GENERAL SURGERY, GYNECOLOGY, OBSTETRICS ORTHOPEDICS, UROLOGY

PRESBYTERIAN HOSPITAL

Tuesday

JOHN H. JOPSON and DAMON B. PFEIFFER—9. General surgery.
FRANK C. KNOWLES and HENRY G. MUNSON—1. Dermatological clinic.
JOHN H. GIRVIN, GEORGE M. LAWS and PHILIP F. WILLIAMS—1:30. Gynecological clinic; pathological exhibit and demonstration of routine work in gynecological dispensary.
W. S. NEWCOMET—2:30. Roentgenology.

Wednesday

J. STEWART RODMAN and HENRY P. BROWN—9. General surgery.
B. A. THOMAS and F. G. HARRISON—2. Demonstration of conduct and equipment of genito-urinary dispensary.
W. S. NEWCOMET—2:30. Roentgenology.
B. A. THOMAS, JOSEPH C. BIRDSALL and F. G. HARRISON—3. Genito-urinary clinic.

Thursday

JOHN SPEESE and W. E. CHRISTIE—9. General surgery.
JOHN EIMAN and W. E. CHRISTIE—2. Demonstration in surgical pathology.
W. S. NEWCOMET—2:30. Roentgenology.

Friday

JOHN H. JOPSON and DAMON B. PFEIFFER—9. General surgery.
W. S. NEWCOMET—2:30. Roentgenology.

HOWARD HOSPITAL

Tuesday

E. L. ELIASON, DRURY HINTON and V. W. M. WRIGHT—10. General surgical clinic; industrial surgery, outline of record system, follow-up; routine surgery.

Wednesday

B. C. HIRST—9. Gynecological clinic.

Thursday

E. L. ELIASON, DRURY HINTON and V. W. M. WRIGHT—10. Fracture clinic, methods and results; routine surgery under local anæsthesia.
S. W. MOORHEAD—4. Genito-urinary clinic, demonstration of use of local anæsthesia in urology.

Friday

B. C. HIRST—9. Gynecological clinic.

FRANKFORD HOSPITAL

Wednesday

W. E. PARKE—9:30. Plastics, plastic and retroversion of uterus.
E. A. SCHUMANN—9:30. Fibroid of uterus, carcinoma of uterus, plastic and section.
G. C. HANNA—9:30. Cæsarian section.
F. E. KELLER—9:30. Cæsarian section, local anæsthesia.

Thursday

CHARLES F. NASSAU—9:30. Cholelithiasis, duodenal ulcer, nephrolithiasis, goiter.
LOUIS D. ENGLERTH—9:30. Hernia under local anæsthesia, fracture clinic.

PENNSYLVANIA HOSPITAL

Tuesday

HENRY B. BROWN and EDWARD STRECKER—9. Dry clinic: The surgical and neurological aspects of fracture of the skull.
GEORGE NORRIS and staff—10. Medical aspects and diagnosis of the cases to be operated upon.
CHARLES F. MITCHELL, WALTER ESTELL LEE, and HENRY B. BROWN—11. General surgical operations.

Wednesday

LEON HERMAN—9. Dry clinic: Genito-urinary cases.
GEORGE NORRIS and staff—10. Medical aspects and diagnosis of cases to be operated upon.
JOHN H. GIBBON, ARTHUR E. BILLINGS, and EDWARD J. KLOPP—11. General surgical operations.

Thursday

JAMES CAMERON—9. Dry clinic: Oral surgical cases.
Staff—10. Demonstration of the surgical pathology of tissues removed at operation in the surgical clinics on the two previous days.
EDWARD F. DILLON—11. Care of diabetics before and after surgical procedure.
W. D. STROUD—12. Heart disease in relation to surgical operation.
CHARLES F. MITCHELL, WALTER ESTELL LEE, and HENRY B. BROWN—1. General surgical clinic.

EPISCOPAL HOSPITAL

Tuesday

RALPH S. BROMER—9. X-ray demonstration.
LOUIS H. MUTSCHLER—11. General surgery.

Wednesday

ASTLEY P. C. ASHHURST, IRVINE M. BOYKIN, and EDWARD T. CROSSAN—9. General surgery.
A. BRUCE GILL, R. L. JOHN, and A. F. MOXEY—2. Orthopedics.

Thursday

E. G. ALEXANDER—9. General surgery.
H. C. DEAVER—11. General surgery.

Friday

E. T. CROSSAN—9. Demonstration in surgical pathology.
L. H. MUTSCHLER—11. General surgery.
JOHN B. HAINES—2. Cystoscopic clinic.

POLYCLINIC HOSPITAL

Tuesday

DEFOREST P. WILLARD—10:30. Orthopedics.
G. E. PFAHLER—2. Radiologic conference.
B. A. THOMAS—2. Urology.

Wednesday

W. G. ELMER—11:30. Orthopedics.

Thursday

COLLIER F. MARTIN—1. Proctology.
J. F. SCHAMBERG—2. Arsphenamin clinic.

Friday

R. H. IVY—9. Plastic surgery of the face.
B. A. THOMAS—2. Urology.
E. A. CASE—2. Surgical pathology.

JEFFERSON HOSPITAL

Tuesday

J. Torrance Rugh—9:30. Orthopedics.
Charles F. Nassau—11. General surgery.
Thomas C. Stellwagen—11. Genito-urinary surgery.
John H. Gibbon—2. General surgery.

Wednesday

Chevalier Jackson—9. Bronchoscopy for diagnosis and treatment of diseases of the lungs.
Brooke M. Anspach and staff—9. Gynecology.
P. Brooke Bland—9. Gynecology.
W. H. Kinney—11. Genito-urinary surgery.
John B. Flick—11. General surgery.
J. Chalmers DaCosta—2. Surgical clinic.

Thursday

H. R. Loux—9. Genito-urinary surgery.
J. M. Fisher—11. Gynecology.
Thomas A. Shallow—11. General surgery.
Arthur Davidson—11. Orthopedic surgery.
Chevalier Jackson, Gabriel Tucker, and Louis Clerf—12:30. Bronchoscopic aspiration in suppurative diseases of the lung.

Friday

Edward J. Klopp—11. General surgery.

ST. MARY'S HOSPITAL

Tuesday

James A. Kelly—9. General surgery.
William J. Ryan—9. General surgery.
Wilbur H. Haines and L. F. Milliken—2. Genito-urinary clinic.
W. T. Rees. Laboratory demonstration.

Wednesday

William A. Steel—9. Abdominal surgery with spinal anæsthesia.
A. P. Keegan—9. General surgery and local anæsthesia.
C. Howard Moore—2. Orthopedic clinic, operations and demonstration of cases.
W. T. Rees. Laboratory demonstration.

Thursday

Frank D. Harris—9. Gynecology.
William F. Morrison—9. Gynecology.
William E. Parke and J. Stuart Lawrence—12:30. Obstetrical clinic, labor room and ward walks. Operations. Prenatal clinic.
W. T. Rees. Laboratory demonstration.

SAMARITAN HOSPITAL

Tuesday

John Leedom, J. O. Bower, G. Mason Astley, John C. Frick, and J. N. Coombs—9. Surgical clinic.
Harry Hudson—2. Orthopedic clinic.
Albert Strickler—3. Dermatology.

Wednesday

W. Wayne Babcock—9. General surgery.
Charles S. Barnes and C. M. Stimson—11. Obstetrics.
Frank C. Hammond—2. Gynecology.
W. Hershey Thomas—4. Genito-urinary surgery.
Harry Z. Hibshman—5. Rectal clinic.

Thursday

A. C. Applegate—11. Obstetrics.

Friday

W. Wayne Babcock—9. General surgery.

MISERICORDIA HOSPITAL

Tuesday

Basil Beltran and staff—9. General surgery.
James A. Kelly and staff—9. General surgery.

Wednesday

George P. Muller and Thomas Ryan—9. General surgery.
J. F. X. Jones, A. E. Burke, and J. J. Cancelmo—12. General surgical clinic; Buerger's disease; a case of tetanus; osteomyelitis following a compound fracture of the pubic bone.

Thursday

Basil Beltran and staff—9. General surgery.
James A. Kelly and staff—9. General surgery.

Friday

George P. Muller and Thomas Ryan—9. General surgery.
J. F. S. Jones, A. E. Burke, and J. J. Cancelmo—12. General surgical clinic; acute osteomyelitis of tibia; repair of perineal laceration; hernioplasty with local anæsthesia.

ST. AGNES HOSPITAL

Tuesday

E. C. Murphy—9. Dry clinic: Exhibition of fracture cases with end-results by operative and non-operative procedures.
John F. X. Jones—9. General surgery, operative clinic.
John A. McGlinn—9. Gynecology. Exhibition of patients treated for acute inflammatory diseases by means of nonspecific proteins. Demonstration of method of treatment of gonorrhœa in the female by heat.

Wednesday

G. M. Dorrance and J. W. Bransfield—9. Operative clinic and demonstration of cases. Cleft palate cases operated on by the new method, elongation of palate.
John M. Fisher—9. Gynecology.
Wilbur B. Haines—2. Genito-urinary surgery.
J. C. Hirst and staff—2. Gynecology and obstetrics.

MEDICO-CHIRURGICAL HOSPITAL

Tuesday

J. B. Carnett—9. General surgery.
George M. Boyd—11. Gynecology.

Wednesday

George W. Outerbridge—9. Cystoscopy.
William R. Nicholson—9. Gynecology.

Friday

J. B. Carnett—9. General surgery.
George M. Boyd—11. Gynecology.

NORTHEASTERN HOSPITAL

Wednesday

H. Z. Hibshman—9. Anorectal infections.
T. Turner Thomas—10. General surgery.
John B. Lownes and J. A. Broadfield—3. Operative and cystoscopic clinic.

Thursday

T. Turner Thomas—2. Dry clinic: Results with non-operative reduction, especially of wrist, elbow, shoulder, hip, and ankle. Operative reductions. Compound fractures. Recurrent dislocations of shoulder. Brachial birth palsy.

UNIVERSITY HOSPITAL

Tuesday

JOHN G. CLARK, C. C. NORRIS, and F. E. KEENE—9. Gynecology.
C. H. FRAZIER, F. GRANT, and TEMPLE FAY—9. Neurosurgery.
B. C. HIRST, E. B. PIPER, J. C. HIRST, II, J. K. JAFFE, G. V. JANVIER, and W. BENSON HARER—9. Obstetrics and gynecology.
GEORGE P. MULLER and I. S. RAVDIN—9. General surgery.
A. BRUCE GILL—9. Orthopedics.
CHEVALIER JACKSON and GABRIEL TUCKER—3. Bronchoscopy.

Wednesday

JOHN G. CLARK, C. C. NORRIS, and F. E. KEENE—9. Gynecology.
E. L. ELIASON and DRURY HINTON—9. General surgery.
A. RANDALL, S. W. MOORHEAD, P. S. PELOUZE, and MAURICE MUSCHAT—2. Urology.

Thursday

JOHN G. CLARK, C. C. NORRIS, and F. E. KEENE—9. Gynecology.
C. H. FRAZIER, F. GRANT, and TEMPLE FAY—9. Neurosurgery.
B. C. HIRST, E. B. PIPER, J. C. HIRST, II, J. K. JAFFE, G. V. JANVIER, and W. B. HARER—9. Obstetrics and gynecology.
G. P. MULLER and I. S. RAVDIN—9. General surgery.
A. BRUCE GILL—9. Orthopedics.
CHEVALIER JACKSON and GABRIEL TUCKER—3. Bronchoscopy.

Friday

JOHN G. CLARK, C. C. NORRIS, and F. E. KEEN —9. Gynecology
C. H. FRAZIER, F. GRANT, and TEMPLE FAY—9. Neurosurgery.
B. C. HIRST, E. B. PIPER, J. C. HIRST, II, J. K. JAFFE, G. V. JANVIER, and W. B. HARER—9. Gynecology and obstetrics.
E. L. ELIASON and DRURY HINTON—9. General surgery.
A. BRUCE GILL—9. Orthopedics.

JEWISH HOSPITAL

Tuesday

M. BEHREND—9. General surgery.
W. H. TELLER—2. General surgery.

Wednesday

F. B. BLOCK—9. General surgery.
L. BRINKMAN—2. General surgery.

Thursday

M. BEHREND—9. General surgery.
F. B. BLOCK—2. General surgery.

Friday

L. BRINKMAN—9. General surgery.
W. H. TELLER—2. General surgery.

WOMEN'S HOMEOPATHIC HOSPITAL

Tuesday

JOHN A. BROOKE—2. Orthopedics.

Wednesday

ARTHUR HARTLEY—2. General surgery.

Friday

FRANCOIS L. HUGHES—10. Gynecology.

PHILADELPHIA GENERAL HOSPITAL

Tuesday

FRANK C. HAMMOND—10. Gynecological operations.
WILLIAM H. MACKINNEY—2. Genito-urinary operations.

Wednesday

ALFRED C. WOOD—9. General surgery.
J. T. RUGH—11. Orthopedic surgery.
STAFF—2. Symposium on Cancer: J. B. CARNETT, general surgery; HENRY K. PANCOAST, Radiology; C. C. NORRIS, gynecology; J. F. SCHAMBERG, dermatology; ROBERT G. TORREY, medical; GEORGE M. DORRANCE, faciomaxillary; F. O. LEWIS, laryngology. Visit to radium emanation plant and deep therapy laboratories.

Thursday

J. B. CARNETT, J. RALSTON WELLS, ROBERT BRADLEY and JAMES P. WEATHERWAX—9. Non-operative cancer clinic.
EDWARD A. SCHUMANN—2. Gynecological operations.

Friday

T. T. THOMAS—9. General surgery.
C. C. NORRIS—11. Gynecological clinic, cancer operations.
EDWARD B. KRUMBHAAR and staff of pathologists—4. Clinicopathological conference, demonstrating current interesting pathological conditions and specimens. Open discussion is invited at this conference.

ST. JOSEPH'S HOSPITAL

Tuesday

JOSEPH M. SPELLISSY—9. Dry clinic: Operative mechanical treatment of some of the effects of infantile paralysis.
JOHN F. X. JONES—11. General surgery; appendectomy, gall-bladder disease.

Wednesday

MELVIN M. FRANKLIN—9. General surgery; influence of prosthetics upon amputations; chronic, nontuberculous suppuration in bone.
F. HURST MAIER—11. Gynecology; hysterectomy for myofibromata, plastic for procidentia, suspension for retroflexion.

Thursday

JAMES A. KELLY—9. General surgery; fracture clinic.

Friday

CHARLES F. NASSAU—9. General surgery; subtotal thyroidectomy under local anæsthesia, hernioplasty under local anæsthesia.
P. BROOKE BLAND—11. Gynecology; application of radium for uterine myofibromata, trachelorrhaphy and perineorrhaphy, abdominal hysterectomy.

NORTHWESTERN GENERAL HOSPITAL

Tuesday

J. O. ARNOLD—2. Obstetrical clinic. Perineotomy, an improved technique.

Wednesday

J. T. SCHELL—9. General surgery.

Thursday

ARTHUR D. KURTZ—3:30. Orthopedic dry clinic.

Friday

ROBERT BOYER—11. Genito-urinary clinic. Suprapubic prostatectomy.

LANKENAU HOSPITAL

Tuesday

STANLEY P. REIMAN—9. Demonstrations in new laboratory.
A. G. MILLER and ROBERT SHOEMAKER—11. Demonstration in roentgenology.
F. L. HARTMAN—11. Demonstration of follow-up system.

Wednesday

STANLEY P. REIMAN—9. Demonstration in new laboratory.
F. L. HARTMAN—11. Demonstration of follow-up system.
A. G. MILLER and ROBERT SHOEMAKER—11. Demonstration in roentgenology.
JOHN B. DEAVER—12. General surgery.

Thursday

F. L. HARTMAN—11. Demonstration of follow-up system.
A. G. MILLER and ROBERT SHOEMAKER—11. Demonstration in roentgenology.
JOHN B. DEAVER—12. General surgery.
WILLIAM H. MACKINNEY—5:30. Cystoscopy.

Friday

STANLEY P. REIMAN—9. Demonstration in new laboratory.
A. G. MILLER and ROBERT SHOEMAKER—11. Demonstration in roentgenology.
F. L. HARTMAN—11. Demonstration of follow-up system.

METHODIST EPISCOPAL HOSPITAL

Tuesday

JAMES H. BALDWIN—9. Gas gangrene, foreign body in bladder, fractures of patella, foreign body in brain.
MILTON F. PERCIVAL—9. Daily demonstrations of X-ray technique, fluoroscopy, pyelograms, electrocoagulation, radio knife, and photography.

Wednesday

WILLIAM R. NICHOLSON—9. Vesicovaginal fistula, cystocele, prolapse of uterus, cervical repairs and repairs of perineum.
LEVI JAY HAMMOND—2. Surgery of gall tracts, stomach, spleen, and pancreas.

Thursday

DAMON B. PFEIFFER—9. Carcinoma of the rectosigmoid, blood transfusions, surgery of the gall bladder, stomach, and intestines.
RICHARD C. NORRIS—2. Abdominal gynecology, retroversion, uterine and ovarian tumors, cæsarean section.

Friday

J. T. RUGH—9. Arthrodesis, correction of paralytic deformities, stabilization of the hip joint and spinal bone grafts.
LEON HERMAN—1. Prostatectomy, renal calculus, hypernephroma, malignant tumors of the bladder, cystoscopy, and pyelography.

KENSINGTON HOSPITAL FOR WOMEN

Tuesday

WILLIAM E. PARKE—11. Prenatal clinic, history taking, pelvimetry, blood-pressure records, obstetrical analgesia.
H. C. DEAVER—12:30. General surgical clinic.

Friday

DANIEL LONGAKER—11. Potter version statistics and demonstration of available material.

CHILDREN'S HOSPITAL

Tuesday

J. H. JOPSON—9. Diagnosis in surgical diseases of the abdomen.
J. C. GITTINGS—9. Some medical aspects of surgical cases.
C. W. BURR and F. E. LEAVITT—9. Neurosurgical problems in children.
C. C. NORRIS—2. Vaginitis in infants and young children; methods of treatment.

Wednesday

W. ESTELL LEE and J. R. WELLS—9. Problems in thoracic surgery. Treatment of burns.
R. S. BROMER—9. X-ray in thoracic and gastro-intestina lesions.

Thursday

HOWARD C. CARPENTER—9. Health examination in children.
EMILY P. BACON—9. Demonstration of nutritional work in children.
SUSAN C. FRANCIS, R. N.—9. Problems in management of surgical wards.

Friday

JOHN SPEESE and W. EDGAR CHRISTIE—9. Postoperative management of surgical cases.
HENRY P. BROWN and ERNEST G. WILLIAMSON—9. Management of the surgical out-patient department.

MT. SINAI HOSPITAL

Tuesday

CHARLES F. NASSAU—9. Radical cure of hernia, local anæsthesia.
G. ROSENBAUM—12. X-rays of gastro-intestinal tract.

Wednesday

M. BEHREND—9. Surgery of bile passageways and gastro-intestinal tract. Presentation of cases.
M. COOPERMAN—2. Gonorrhœal arthritis, dislocation of hip, astragalectomy, Whitman reconstruction operation.
G. TUCKER—4. Bronchoscopy and œsophagoscopy.

Thursday

J. C. HIRST—9. Prolapse of uterus, cystoscopy, vaginal repair.
G. ROSENBAUM—12. X-rays of gastro-intestinal tract.
G. TUCKER—4. Bronchoscopy and œsophagoscopy.

Friday

C. MAZER—9. Plastic, Rubin test, and pyelography.
C. HIRSH—11:30. Demonstration of cases.

AMERICAN ONCOLOGIC HOSPITAL

Tuesday

W. S. NEWCOMET—10. Cases of angioma, treated and under treatment, selected from a group of 200.
SAMUEL MCCLARY, 3rd—10. Cases of cancer of the lip and mouth.

Wednesday

W. S. NEWCOMET and SAMUEL MCCLARY, 3rd—9:30. Cases of malignant diseases being treated with radium: cases of angioma, cancer of the lip, birth mark.

Friday

W. S. NEWCOMET and SAMUEL MCCLARY, 3rd—9:30. Cases of malignant diseases being treated with radium; review of goiter cases treated with radium.

HAHNEMANN HOSPITAL

Tuesday

L. T. Ashcraft, William C. Hunicker, Frank C. Benson, Jr.—9. Urologic clinic. Symposium on tumors of the urinary bladder and on carcinoma of the prostate. Demonstration of local anæsthesia.

J. E. James, Jr., and Leon Clemmer—10. Obstetrical clinic. Salient points in pelvimetry. The rôle of version in obstetrical surgery. Cervico-abdominal hysterectomy.

F. W. Smith—2. Bronchoscopic work on the cadaver.

F. C. Benson, Jr.—3. Radium clinic. Technique of application and results in superficial malignant tumors. Limitations, contra-indications, and dangers in radium therapy.

Wednesday

H. L. Northrop—9. Thoracic surgery.

D. B. James and E. B. Craig—9. Gynecological clinic. Malignancy of the uterus.

W. C. Mercer and J. B. Bert—10. Obstetrical clinic. Forceps application with special reference to the cephalic application in posterior oblique positions. The mechanism of labor.

S. W. Sappington—3. Demonstration of various methods of blood transfusion.

Thursday

J. D. Elliott and William M. Sylvis—9. Operative clinic. Tumors of the breast. Discussion of the pathology and end-results of treatment by X-rays, radium, and operation.

D. B. James—9. Gynecological clinic.

O. B. Waite and N. F. Paxson—10. Obstetrical clinic. Prenatal care. Practical results of routine Wassermann tests. Pre-eclampsia and eclampsia. Fetal mortality.

J. A. Brooke—2. Orthopedic clinic. Shortening of bones of the leg to correct inequality in length. Demonstration of new bone skid. Results of astragalectomy in paralytic foot.

J. W. Frank—3. Roentgenologic clinic. Comparison of newer forms of roentgen treatment for malignancy with former methods. Presentation of patients.

Friday

G. A. Van Lennep and H. P. Leopold—9. Surgery of the stomach and duodenum.

N. F. Lane and D. W. Culin—9. Uterine bleeding, diagnosis and treatment.

ORTHOPEDIC HOSPITAL

Tuesday

Astley P. C. Ashhurst, Rutherford L. John, Edward T. Crossan, and B. F. Buzby—1. Orthopedic demonstration.

Thursday

Astley P. C. Ashhurst, Rutherford L. John, Edward T. Crossan, and B. F. Buzby—9. Orthopedic operations.

Friday

A. Bruce Gill, C. R. Bowen, and James E. Wyant. Orthopedic clinic.

ST. CHRISTOPHER'S HOSPITAL

E. G. Alexander—10. Surgical clinic: Hernia, appendix, pyloric stenosis, undescended testicle, harelip, empyema and bone cases. Surgery in children.

WOMAN'S HOSPITAL

Tuesday

Sarah H. Lockrey and Emily Whitten-Auge—9. Gynecological clinic.

Lida Stewart-Cogill and Elizabeth Hughes—2. Obstetrical clinic.

Julia Hardin. Demonstration of gas-oxygen and ethylene anæsthesia.

Wednesday

Marie K. Formad and Alberta Peltz—9. Gynecological clinic.

Ella Williams Grim and Alberta Peltz—3. Obstetrical clinic.

Julia Hardin. Demonstration of gas-oxygen and ethylene anæsthesia.

Thursday

Catharine Macfarlane and Faith S. Fetterman—9. Gynecological clinic.

Kate W. Baldwin—10. General surgery.

Mary Lewis and Della Mildazias—3. Obstetrical clinic.

Julia Hardin. Demonstration of gas-oxygen and ethylene anæsthesia.

Friday

Elizabeth F. C. Clark—10. Gynecological clinic.

Ann Tomkins Gibson and Jessie W. Pryor—2. Obstetrical clinic.

Emily Whitten-Auge—3. General surgery.

Julia Hardin. Demonstration of gas-oxygen and ethylene anæsthesia.

ST. LUKE'S HOSPITAL

Tuesday

Desiderio Roman—9. General surgery.

O. F. Barthmaier—11. Demonstration of blood transfusion.

Wednesday

A. B. Webster—9. General surgery.

J. Walter Post—11. Demonstration in roentgenology.

William C. Hunsicker and J. Miller Kenworthy—2. Genito-urinary surgery and cystoscopy.

Thursday

Desiderio Roman—9. Operations upon thyroid and demonstration of group study of thyroid disease.

Friday

A. B. Webster—9. General surgery.

J. Walter Post—11. Demonstration in roentgenology.

William C. Hunsicker and J. Miller Kenworthy—2. Genito-urinary surgery and cystoscopy.

CHILDREN'S HOMEOPATHIC HOSPITAL

Tuesday

H. P. Leopold—2. General surgery.

Wednesday

John Brooke—2. Orthopedic clinic: After-results in epiphyseal fractures; club hand; syphilitic joints; joint changes in endocrine disturbances.

Thursday

A. Korndoerfer, Jr.—2. Obstetrical clinic.

STETSON HOSPITAL

Tuesday

JOHN A. BOGER and WILLIAM T. ELLIS—1. General surgery; herniotomy, appendectomy, cholecystotomy, reduction of fractures.

Wednesday

S. E. TRACY and Associates—9. Gynecological clinic. Plastic operations, trachelorrhaphy, trachelectomy, anterior colporrhaphy, perineorrhaphy, myomectomy and hysterectomy for fibroids, shortening of the round ligaments, conservative operations for pelvic inflammatory conditions.

Thursday

BROOKE M. ANSPACH and Associates—9. Gynecological clinic.

Friday

S. E. TRACY and Associates—9. Gynecological clinic.
CARL F. KOENIG—1. Roentgenology. Diagnostic and deep therapy clinic.

WOMAN'S COLLEGE HOSPITAL

Tuesday

LIDA STEWART-COGILL—9. Prenatal clinic.

Wednesday

J. S. RODMAN and staff—9. General surgery.

Thursday

CATHARINE MACFARLANE—2. Gynecology.

Friday

J. S. RODMAN and staff—9. General surgery.

COOPER HOSPITAL (Camden)

Tuesday

THOMAS B. LEE, ALBERT B. DAVIS, and GORDON WEST—9. Gynecology.

Wednesday

PAUL M. MECRAY and Associates—10. General surgery.
A. HAINES LIPPINCOTT and DAVID BENTLEY, JR.—2:30. Genito-urinary and rectal clinic.
B. F. BUZBY—2:30. Orthopedic clinic.

Thursday

THOMAS B. LEE, ALBERT B. DAVIS, and GORDON WEST—9. Gynecology.

Friday

PAUL M. MECRAY and Associates—10. General surgery.
B. F. BUZBY—2:30. Orthopedics.

CHESTNUT HILL HOSPITAL

Tuesday

ANDREW GODFREY and WILLIAM SHEEHAN—10. General surgery.
ALEX RANDALL—2. Urological clinic.

Wednesday

J. MURRAY ELLZEY—10. Fracture clinic.

Thursday

J. F. MCCLOSKEY—10. General surgery.

EVANS INSTITUTE

R. H. IVY and LAWRENCE CURTIS—Wednesday, 10. Oral surgery.

SURGERY OF THE EYE, EAR, NOSE AND THROAT

CLINICAL DEMONSTRATIONS AND PAPERS

Ballroom, Bellevue-Stratford

Tuesday—9 a.m.

Group conference on problems related to the Hospital Standardization Program as applied to ophthalmological and otolaryngological services. J. A. BABBITT, Chairman.

Wednesday—9 a.m.

PHILIP FRANKLIN, London, England: The Clinical Aspect of Tonsils.
Discussion: GEORGE B. WOOD, Philadelphia; C. W. RICHARDSON, Washington; C. G. COAKLEY, New York.

CHEVALIER JACKSON, Philadelphia: Laryngofissure for Cancer of the Larynx.
Discussion: HARMON SMITH, New York; H. W. LOEB, St. Louis; LOUIS H. CLERF, Philadelphia.

HARRY S. GRADLE, Chicago: The Practical Use of the Slit Lamp in Daily Routine.
Discussion: HUNTER H. MCQUIRE, Winchester, Va.; ALFRED COWAN, Philadelphia; LUTHER C. PETER, Philadelphia.

DOUGLAS QUICK, New York: Use of Radium and X-ray in the Treatment of Malignant Disease of the Paranasal Sinuses.
Discussion: D. CROSBY GREENE, Boston; CHARLES E. PANCOAST, Philadelphia; G. E. PFAHLER, Philadelphia.

JOHN E. MACKENTY, New York: Laryngectomy in One Stage, Comments on One Hundred Operations.
Discussion: FIELDING O. LEWIS, Philadelphia.

Thursday—9 a.m.

F. EARNEST WHITNALL, Montreal, Canada: Tenon's Capsule.

J. C. BECK, Chicago: Some of the Important Complications from Ear, Nose and Throat Diseases and Operations and Their Management.
Discussion: GEORGE M. COATES, Philadelphia; RALPH BUTLER, Philadelphia.

E. C. ELLETT, Memphis, Tenn.: The Use of the Suture in Cataract Extraction.
Discussion: LEWIS ZIEGLER, Philadelphia; WILLIAM ZENTMAYER, Philadelphia.

WELLS P. EAGLETON, Newark, N. J.: Meningitis of Aural Origin.
Discussion: S. MACCUEN SMITH, Philadelphia; JAMES A. BABBITT, Philadelphia; H. I. LILLIE, Rochester, Minn.

T. E. CARMODY, Denver: Observations of Children's Sinuses in Health and Diseases.
Discussion: ROSS H. SKILLERN, Philadelphia; LEON E. WHITE, Boston.

Friday—9 a.m.

MAJOR EDMUND B. SPAETH, Takoma Park, Md.: Ophthalmic Plastic Surgery. Lantern slide demonstration.

GEORGE M. DORRANCE, Philadelphia: Rhinoplasty, presentation of cases and lantern slide demonstration.

WARREN B. DAVIS, Philadelphia: Some Types of Harelip and Cleft-palate Deformities and Their Operative Results. Presentation of patients and lantern slide demonstration.

CHARLES F. NASSAU, Philadelphia: Closure of Laryngostomic Fistulæ. Lantern slide and moving picture demonstration.

EPISCOPAL HOSPITAL

Tuesday

W. R. WATSON, E. W. COLLINS, O. C. HIRST, and J. H. SCHAEFFER—2. Otolaryngology.
HAROLD G. GOLDBERG, D. J. BOONE, and WILLIAM H. CHANDLEE—2. Ophthalmology.

Wednesday

A. G. FEWELL, W. S. REESE, J. B. RUDOLPH, and F. HERBERT, JR.—2. Ophthalmology.
W. R. WATSON, E. W. COLLINS, O. C. HIRST, and J. H. SCHAEFFER—2. Otolaryngology.

Thursday

FREDERICK KRAUSS and J. B. FELDMAN—2. Ophthalmology.
CHARLES C. BIEDERT, T. R. CURRIE, and WILLIAM MATTHEWS—2. Otolaryngology.
A. G. FEWELL, W. S. REESE, J. B. RUDOLPH, and F. HERBERT, JR.—2. Ophthalmology.

Friday

C. C. BIEDERT, T. R. CURRIE, and WILLIAM MATTHEWS—2. Otolaryngology.
HAROLD G. GOLDBERG, D. J. BOONE, and W. H. CHANDLEE—2. Ophthalmology.

POLYCLINIC HOSPITAL

Tuesday

T. B. HOLLOWAY—2. Ophthalmology.

Wednesday

WALTER ROBERTS—2. Otolaryngology.
E. B. GLEASON—3. Otolaryngology.
L. C. PETER—3. Ophthalmology.

Thursday

GEORGE B. WOOD—3. Laryngology.

Friday

RALPH BUTLER—3. Laryngology.

HOWARD HOSPITAL

Tuesday

G. B. WOOD—2. Laryngology.

Wednesday

W. C. POSEY—2. Operations on the eye.

Thursday

G. B. WOOD—2. Laryngology.

Friday

W. C. POSEY—2. Ophthalmology.

ST. AGNES HOSPITAL

Tuesday

BENJAMIN D. PARISH—2. Otolaryngology.

Wednesday

WARREN B. DAVIS—2. Otolaryngology.
GEORGE F. J. KELLY—2. Ophthalmology.

ST. JOSEPH'S HOSPITAL

Tuesday

GEORGE M. MARSHALL—2. Otolaryngology; osteoplastic correction of the nasal bones, radical maxillary sinus operation.

PAUL J. PONTIUS—2. Ophthalmology; enucleation with gold ball insertion, iridectomy.

Wednesday

CHARLES J. JONES—2. Ophthalmology; preliminary iridectomy for cataract, simple extraction.

WILLIAM E. QUICKSALL—2. Otolaryngology; tonsillectomy by Fetterolf's method, submucous resection.

Thursday

THOMAS A. O'BRIEN—2. Ophthalmology; combined extraction, Elliott trephine for glaucoma.

ARTHUR WRIGLEY—2. Otolaryngology; replacement of laterally displaced tip of quadrangular cartilage with submucous resection, tonsillectomy by decapsulation with dissection and snare.

CORNELIUS T. MCCARTHY—2. Otolaryngology; radical mastoidectomy, ethmoidectomy.

JEFFERSON HOSPITAL

Thursday

FIELDING O. LEWIS—2. Otolaryngology.

Friday

HOWARD F. HANSELL and WILLIAM M. SWEET—2. Ophthalmology.

S. MACCUEN SMITH and J. CLARENCE KEELER—2. Otology.

MISERICORDIA HOSPITAL

Tuesday

JOHN E. LOFTUS—2. Otolaryngology.

Wednesday

C. T. MCCARTHY—2. Otolaryngology.

HAROLD GOLDBERG—3. Ophthalmology.

Thursday

JOHN E. LOFTUS—2. Otolaryngology.

JOHN A. COLGAN—3. Ophthalmology.

Friday

C. T. MCCARTHY—2. Otolaryngology.

WOMAN'S COLLEGE HOSPITAL

Tuesday

MARGARET F. BUTLER—2. Otolaryngology.

Friday

MARY BUCHANAN—3. Ophthalmology.

JEWISH HOSPITAL

Wednesday

J. KNIPE—3. Eye clinic.

Thursday

S. MCC. SMITH and A. S. KAUFMAN—3. Otological clinic.

H. M. GODDARD—4. Nose and throat clinic.

WILLS EYE HOSPITAL

Tuesday

BURTON CHANCE, FRANK C. PARKER, LEIGHTON F. APPLEMAN, and BENJAMIN F. BAER, JR.—2. Ophthalmic operations.

Wednesday

WILLIAM ZENTMAYER, PAUL J. PONTIUS, J. MILTON GRISCOM, and THOMAS A. O'BRIEN—2. Ophthalmic operations.

Thursday

BURTON CHANCE, FRANK C. PARKER, LEIGHTON F. APPLEMAN, and BENJAMIN F. BAER, JR.—2. Ophthalmic operations.

Friday

WILLIAM ZENTMAYER, PAUL J. PONTIUS, J. MILTON GRISCOM, and THOMAS A. O'BRIEN—2. Ophthalmic operations.

UNIVERSITY HOSPITAL

Tuesday

THOMAS B. HOLLOWAY—2. Ophthalmology.

G. FETTEROLF, J. A. BABBITT, D. HUSIK, and LEWIS FISHER—3. Otolaryngology.

Wednesday

G. FETTEROLF, J. A. BABBITT, D. HUSIK, and L. FISHER—3. Otolaryngology.

Thursday

THOMAS B. HOLLOWAY—2. Ophthalmology.

Friday

THOMAS B. HOLLOWAY—2. Ophthalmology.

GEORGE FETTEROLF, J. A. BABBITT, DAVID HUSIK and LEWIS FISHER—2. Otolaryngology.

MT. SINAI HOSPITAL

Tuesday

L. FISHER—2. Tonsil and sinus surgery. Bárány test.

C. W. LEFEVER—4. Cataract, glaucoma, muscle work.

Thursday

S. J. GITTELSON—2. Demonstration of cases.

Friday

A. W. WATSON—2. Mastoid and tonsil surgery.

METHODIST EPISCOPAL HOSPITAL

Tuesday

WALTER ROBERTS—2. Deviated septum, tonsillectomies and adenoidectomies, mastoid disease and malignant disease of the larynx, bronchoscopy.

PHILIP H. MOORE—4. Enucleation, foreign body in the eye, strabismus, glaucoma.

CHILDREN'S HOSPITAL

Wednesday

H. MAXWELL LANDON and A. R. RENNINGER—2. Ophthalmology.

Thursday

JAMES A. BABBITT and Staff—2. Otolaryngology.

MEDICO-CHIRURGICAL HOSPITAL

Tuesday

GEORGE M. COATES—2. Otolaryngology.

Wednesday

ROSS H. SKILLERN—2. Laryngology.

Thursday

GEORGE M. COATES—2. Otolaryngology.

Friday

ROSS H. SKILLERN—2. Laryngology.

ST. MARY'S HOSPITAL

Tuesday

FRANK MURPHY—2. Eye clinic.

Wednesday

EDWARD MURPHY, WILLIAM P. GRADY, and ALBERT J. DEVLIN—3. Otolaryngology.

HAHNEMANN HOSPITAL

Tuesday

G. J. PALEN—2. Résumé of mastoid operation by otological department.

Thursday

H. S. WEAVER and C. B. HOLLIS—2. Nose and throat clinic.

Friday

F. O. NAGLE—2. Eye clinic. Pathology of the eye.

STETSON HOSPITAL

CARLE L. FELT and Associates—1. Otolaryngological clinic: Tonsillectomy and adenoidectomy, mastoidectomy, resection of septum.

NORTHEASTERN HOSPITAL

Wednesday

GEORGE E. SHAFFER—2. Caldwell-Luc operation.
CRANVILLE A. LAWRENCE—4. Ophthalmology.

UNIVERSITY OF PENNSYLVANIA MEDICAL SCHOOL

E. B. GLEASON and PHILIP S. STOUT. Operative work on the mastoid and labyrinth. Demonstration on the cadaver.

SAMARITAN HOSPITAL

LUTHER C. PETER—Tuesday, 4. Ophthalmology.

PRESBYTERIAN HOSPITAL

Friday

NATHAN P. STAUFFER, W. L. CARISS, and O. R. KLINE—2. Otolaryngology.
H. MAXWELL LANGDON and J. MONROE THORINGTON—2. Ophthalmology.

WOMAN'S HOSPITAL

Tuesday

LAURA E. HUNT and MARY HIPPLE—2. Otolaryngology.

Wednesday

MARGARET A. WARLOW—1:30. Otolaryngology.
MARY BUCHANAN—2. Ophthalmology.

Thursday

MARGARET F. BUTLER and LOIS VAN LOON—2. Otolaryngology.

CHESTNUT HILL HOSPITAL

Wednesday

BENJAMIN PARISH and JOHN DAVIES—2. Otolaryngology.

Thursday

CARL WILLIAMS—2. Ophthalmology.

COOPER HOSPITAL (Camden)

Tuesday

L. B. HIRST, E. R. HIRST, and ALFRED ELWELL—2:30. Otolaryngology.

Thursday

L. B. HIRST, E. R. HIRST, and ALFRED ELWELL—2:30. Otolaryngology.

FRANKFORD HOSPITAL

Tuesday

FRANK EMBERY—9:30. Tonsil and mastoid clinic.
W. J. WATSON—9:30. Tonsil clinic.

CHILDREN'S HOMEOPATHIC HOSPITAL

FRED W. SMITH—Tuesday, 2. Laryngological clinic, hypertrophied tonsils and adenoids.

WOMEN'S HOMEOPATHIC HOSPITAL

JOSEPH F. V. CLAY—Thursday, 2. Otolaryngology.

PHILADELPHIA GENERAL HOSPITAL

DAVID N. HUSIK—Friday, 2. Otolaryngological operations.

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